



**BlueCross BlueShield  
of Massachusetts**

An Independent Licensee of the  
Blue Cross and Blue Shield Association

**Please Read The Instructions  
Before Filling Out This Form.**



## Enrollment and Change Form

Please mail to: M.I.I.A., 60 Temple Place, Boston, MA 02111

### 1. To Be Filled Out by Your Employer

Company Name				Current Medical Group				Medical Group Transferring To					
Current BCBS ID Number, if any				Requested Effective Date MM DD YYYY		Date of Hire MM DD YYYY		Initial Eligibility Date MM DD YYYY		Current Dental Group		Dental Group Transferring To	
<b>Type of Transaction</b> Add <input checked="" type="checkbox"/> Change <input checked="" type="checkbox"/> Cancel <input type="checkbox"/> (Please fill in termination code, see instructions)				<b>Remarks: (i.e., qualifying event for a new add, change to family, or further instruction)</b>									

### 2. Tell Us About Yourself (Member 1)

<b>What product are you selecting?</b> HMO Blue <input checked="" type="checkbox"/> Network Blue <input checked="" type="checkbox"/> Blue Choice <input checked="" type="checkbox"/> Dental Blue <input checked="" type="checkbox"/> HMO Blue New England <input checked="" type="checkbox"/> Blue Choice New England <input checked="" type="checkbox"/> PPO <input checked="" type="checkbox"/> Other (write name of Plan) <input checked="" type="checkbox"/>										<b>Kind of Membership (Medical)</b> Individual <input checked="" type="checkbox"/> Family <input checked="" type="checkbox"/>				<b>Kind of Membership (Dental)</b> Individual <input checked="" type="checkbox"/> Family <input checked="" type="checkbox"/>			
Your First Name				M.I.				Last Name				Sex		Date of Birth MM DD YYYY			
Street Address / P.O. Box No.						Apt. No.		City/Town				State		Zip Code			
Social Security No.				Home Telephone No. (include area code)				PCP Number				Is this your current PCP? Mark X, if yes. <input checked="" type="checkbox"/>					
Name of PCP				City/Town		Other Insurance? Y / N		Other Insurance Company Name				City/State					
Are you or anyone Listed Below Covered by Medicare? * Y / N				Part A Effective Date MM DD YYYY		Part B Effective Date MM DD YYYY		Medicare No. <input checked="" type="checkbox"/> 65+ <input checked="" type="checkbox"/> disabled <input checked="" type="checkbox"/> ESRD				Actively Working Y / N Retired Y / N If yes, date:					

\* If you have not indicated yes or no regarding your Medicare status, you may receive a follow-up questionnaire.

### 3. Tell Us About Your Spouse (Member 2)

Spouse's First Name				M.I.				Spouse's Last Name				Sex		Date of Birth MM DD YYYY	
Social Security No.				Home Telephone No. (include area code)				PCP Number				Is this your current PCP? Mark X, if yes. <input checked="" type="checkbox"/>			
Name of PCP				City/State		Other Insurance? Y / N		Other Insurance Company Name				City/State			
Part A Effective Date MM DD YYYY				Part B Effective Date MM DD YYYY		Medicare No. <input checked="" type="checkbox"/> 65+ <input checked="" type="checkbox"/> disabled <input checked="" type="checkbox"/> ESRD				Actively Working Y / N Retired Y / N If yes, date:					

### 4. Tell Us About Your Dependents (Members 3, 4, and 5)

Child's First Name				M.I.				Child's Last Name				Sex		Full-time student? Age 19 or over Y / N	
Date of Birth MM DD YYYY		Social Security No.		PCP Number				Name of PCP				Is this your current PCP? Mark X, if yes. <input checked="" type="checkbox"/>			
Child's First Name				M.I.				Child's Last Name				Sex		Full-time student? Age 19 or over Y / N	
Date of Birth MM DD YYYY		Social Security No.		PCP Number				Name of PCP				Is this your current PCP? Mark X, if yes. <input checked="" type="checkbox"/>			
Child's First Name				M.I.				Child's Last Name				Sex		Full-time student? Age 19 or over Y / N	
Date of Birth MM DD YYYY		Social Security No.		PCP Number				Name of PCP				Is this your current PCP? Mark X, if yes. <input checked="" type="checkbox"/>			

The information here is complete and true. I understand that Blue Cross and Blue Shield will rely on this information to enroll me and my dependents or to make changes to my membership. I understand that I should read the subscriber certificate or benefit booklet provided by my employer to understand my benefits and any restrictions that apply to my health care plan. I authorize Blue Cross and Blue Shield to obtain medical records or information from the Social Security Administration, Medicare contractors, other health care programs, insurers or any government agency to verify eligibility, claims payment information or properly coordinate benefits.

Employee's Signature

Date

Employer's Signature

Date

3880-D (12/04)